FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

DETAILS OF CLAIM FOR DEATH BENEFIT

Policy/Proposal No.		Intimation by	
Client Id.		Contact No.	
Relationship with the insured			
Complete Mailing Address			

DETAILS OF DEATH

1. Name of the deceased
2. Died at: ☐ Home ☐ Hospital ☐ Road ☐ Elsewhere
3. If in hospital, provide us with following details:
   - Name of the Hospital
   - Address
   - Contact Nos.
   - Date of Admission
   - Date of Death
   - Name of Attending Doctor
4. What was the diagnosis
5. Date of Death [D][D][M][M][Y][Y][Y][Y]
6. Place of Death
   Time of Death
7. Cause of Death
8. Who certified the cause of death?
9. Was the death reported to police? ☐ Yes ☐ No
   If Yes - Please provide details (Name, address & contact no. of police station where reported)
10. Was a Post Mortem Examination performed? ☐ Yes ☐ No
    If Yes - Please provide details (Name of Hospital, date, time, and contact no. e-mail)

Signature

Name of Branch Manager/ Branch Operation Executive

Branch

Date [D][D][M][M][Y][Y][Y][Y]

Incase, Intimation is through direct walk-in at HO/Zone/Branch

Signature of the person intimating

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REQUEST FOR DEATH CLAIM

(To be filled in by person legally entitled to the claim amount)

Please answer all questions, use "not applicable" (N/A) as appropriate. Do not leave any question blank. Counter-sign where amendments/alterations are made in the replies in the form.
The filling of this form is not to be construed as an admission of liability on the part of Future Generali India Life Insurance Company Limited (the " Company") No agent has been or is authorized to admit any liability on behalf of the Company.

I. Claimant's Details

Claimant's Name In Full			
Age & Gender			
Correspondence Address & Contact No:			
Relationship with the deceased.			
In what capacity are you claiming? (Please tick one)	☐ Nominee ☐ Appointee ☐ Legal Heir ☐ Poli cyholder ☐ Others _____		
Bank Account No (*)		Type of Account	
Name as appearing in the Bank Account (*)			
Bank Name & Branch (*)			
*** Please attach a copy of your Bank passbook / bank statement as proof of above bank account**			
Resident for Tax purpose in jurisdiction(s) outside India : Yes / No (Please Tick as applicable) (If Yes : Please submit FATCA Declaration)			

II. Details of the Life Assured

Full name of the Life Assured			
Date of Birth			
Last Occupation & Duties			
Date when last attended to work		**Annual Income**	
Employer Name & Address			
Address at the time of death			
Date of Death		**Time of Death**	
Cause of Death			
Place of Death			
Name, Address & Tel. Nos. of doctor / hospital certifying death			
Was a postmortem carried out? If Yes, please provide Name, Address & Tel. No of Hospital. **Any additional information?**			

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III. Lifestyle

Did the Life Assured consume Alcohol/ drugs?	☐ Yes ☐ No If Yes, i. Quantity: _____glass/peg per _____ ii. Since when _____
Did the Life Assured Smoke or otherwise use tobacco products?	☐ Yes ☐ No If Yes, i. Quantity: _____sticks/packets per _____ ii. Since when _____

IV.A. Details of illness

Nature of illness/ailment	
Duration of Illness/ailment	
When did the insured complain of or showed symptoms of his/her last illness?	
When did the insured first seek medical treatment for his/her last illness?	
People present at the time of death (Please provide details)	

IV.B. Details of Family Doctor

Name of the Doctor(s)	
Address & Contact Nos.	

IV.C. Name and address of the doctors who had attended / the hospitals where the Life Assured was treated during his last illness:-

Name of Doctor/Hospital	Address	Date of Consultation	Diagnosis

IV.D. In case of death due to Accident

Brief details of accident (with Reg. No. of vehicles involved)			
Was the Life Assured Driving vehicle?	☐ Yes ☐ No (If Yes, please provide copy of Driving License)		
Date & Time of accident		**Place of Accident**	
Name, address & Tel No. of the hospitals .where the Life Assured was admitted after the accident			
Name, Address & Tel. Nos. of police station where accident was reported.			

V. Assignments / Reassignments

Is the policy Assigned ☐ Yes ☐ No

Is the policy Reassigned ☐ Yes ☐ No

Name and Address of the Assignee _____

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VI. Details of Life Insurance Coverage by other companies

Name of Insurance Cos.	Policy Nos. and Type.	Commencement Date	Sum Assured	Claim Status

VII. DECLARATION & AUTHORIZATION

I _____ do hereby declare that the information given on this death claim request form is true and complete to the best of my knowledge and belief and all documents submitted are genuine and duly authenticated. I/we understand that in case any of the above information is found to be false or fabricated, the Company at its discretion may repudiate the claim amount and take necessary action against me.

I hereby authorize the Hospital(s) / Doctor(s) / Laboratories who have examined or treated the deceased for any ailment or illness to provide Future Generali India Life Insurance Company Limited and its authorised representatives/claims investigators such information regarding the deceased's state of health which such hospital, doctor or laboratory may have acquired before or after the policy was issued on the life of _____ by Future Generali India Life Insurance Company Limited . I also authorize the deceased Employer (including any previous employers) to provide information regarding the employment, leave record and medical assistance availed of by the deceased during the tenure of his employment. I further authorize any government organization/undertaking (including the Police or Revenue) to make available to the company or to person or agency as may be authorized by the said company, such information and records as may be needed by it to process a claim. I shall not have any objection, in case Company obtains any document pertaining to life assured or me in relation to or in respect of the abovesaid Policy or otherwise as may be required.

I agree to provide and furnish any other details and reports as and when required by Future Generali India Life Insurance Company Limited for processing my claim.

Signature of Witness

Signature/Thumb Impression of Claimant

Name of witness _____ **Place:** _____

Address _____ **Date:** _____

_____

VIII. VERNACULAR DECLARATION: If the Claimant signs in vernacular or affixes a thumb impression, the witness should also sign the following:

I certify that the contents of this form were explained to the Claimant in _____ (language) and he/she has affixed his/her thumb impression after fully understanding the same.

Signature _____ **Address** _____

_____

Full Name _____ **Contact Nos.** _____

Designation _____

Note: This declaration must be witnessed by any one of the following Employer, Advocate, Bank Manager, Officer,/Notary, Doctor, Gazette Officer, Head Master of a High School, Head Post Master or Departmental Sub-Post Master, Magistrate or President of a Village or Local Body or a Branch Manager of our Company .

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List of Requirements: Please tick the documents submitted

	Tick √ Attached
For Pension Plans without Term Rider	
1. Death Certificate	
2. Medical Cause of Death Certificate	
3. Original Policy Document	
4. Photocopy of Bank Passbook	
5. Life Assured's Photo ID and Date of Birth Proof	
6. Claimant's Photo ID and Date of Birth Proof	
7. Relationship proof of Claimant with Life Assured	
Additional requirements in case of Non-Accidental cause of death	
8. Medical Questionnaire	
9. All hospital papers of hospitalisations in last 5 years	
10. Employer Questionnaire	
Additional Documents in case of Accidental/Suicide/Murder cases	
11. Post Mortem Report	
12. Chemical Viscera Report (if done)	
13. First Information Report (FIR) by Police	
14. Panchnama/Inquest Panchnama	
15. Final Investigation Report by Police	
16. Newspaper Cutting ,if any	
17. Driving License, only if Life Assured was driving at the time of accident	

- **All the documents submitted to us should be in Original or photocopies duly attested by a Gazetted Officer/SEM / Magistrate or a person of local standing/ Sarpanch/ Talathi/ Tahsildar or Police Sub-Inspector or Branch Manager of our company**
- **All medical reports, documents and certification shall be issued by the attending physician and who is qualified to provide such document/certification according to Indian Laws**
- **In addition to the above documents the Company reserves the rights to ask for more documents/information as may be required in consideration of the claim.**
- **Notification of claim, submission of claim forms and/or claim documents to the Company shall not be construed as an admission of liabilities of the Company. No agent is authorized to admit any liabilities on behalf of the Company, or to alter this list of documents or any claim requirements called for by the Company.**

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MEDICAL QUESTIONNAIRE FOR DEATH CLAIM

(To be filled by the physician who last attended the Insured)

Policy No.		Claim no.	

INFORMATION ABOUT THE DECEASED

1. Full Name			
2. Father/Husband's Name			
3. Address			
4. Age (years)		Gender	☐ Male ☐ Female

DEATH & ILLNESS DETAILS

1. Date on which you were **First consulted for current illness:**
2. Date on which you have **Last attended for current illness:**
3. What was the mode of approach: ☐ Himself ☐ Family Relatives ☐ Friends ☐ Neighbours

4. Date of Death	⌊	5. Time of Death	☐ am ☐ pm
6. Primary cause of death			
7. Antecedent cause of death		8. Place of Death	
9. First date of diagnosis			

10. How long, in your opinion did deceased had been suffering from this disease/condition?

11. While examining the Life Assured, have you seen any past medical records?
If Yes, please share details (Attach copies- if available)

12. Who certified the cause of death? If certified by yourself, please attach a copy of the Medical Cause of Death Certificate

13. Physician's Signature & seal/stamp:

14. Was the Post Mortem conducted? If Yes, please provide details of the hospital

15. Any other significant condition/cause contributing to the death: (e.g. Alcohol consumption, Smoking, Drug abuse etc. along with quantity & duration of its consumption)

16. Have you treated or given any advise on illness to the deceased during past 5 years prior to last illness? If yes, please provide details?

17. Did the deceased, to your knowledge, receive treatment during the last 5 years, from any other physician, or in any hospital or institution? If yes, please provide the details:

Name of Hospital/Doctor	Date of Consultation	Symptoms/Complaints	Diagnosis/ Tests undergone

18. Any additional information (pertaining to deceased past medical history/Life style) which could help us to process the claim?

ereby declare that the information provided above is true and correct to the best to my personal knowledge & belief and nothing as been concealed therefrom.

Physician's Name: Dr. _____ Signature & seal/stamp _____

Name & Address of Hospital/Clinic _____

_____

Registration No. _____ Tel. /Mobile no.: _____

Date _____ Place _____

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EMPLOYER QUESTIONNAIRE

Policy No.		Claim No.	

1. LIFE ASSURED'S INFORMATION

Name of the Life Assured			
Address of the Life Assured			
Date of Birth			
Date of joining		Date of resignation/Last date of Work	
Last designation held			

2. DETAILS OF ILLNESS/DEATH

Date of intimation of illness/accident	
Symptoms complained of	
Date of Symptom/Accident	
Date of Death	
Who intimated the death of the deceased?	
Brief Details of Illness/Accident	

3. LEAVE PARTICULARS

Leave particulars of the deceased for the period from to

Nature of leave	Dates of leave	Date of Joining	If Sick leave, Medical Certificate received or not (If yes, provide copy)

4. ANY OTHER INFORMATION

5. EMPLOYER DECLARATION

I/We hereby declare that the above information has been verified by us to the best of our knowledge and belief.

Name of Signatory		Company Name	
Designation		Company Address	
Signature			
Date		Company Seal/Stamp	